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WYO-203 (06/04)

OFFICE USE ONLY:
LO#:
BYE:

Claimant's Medical Separation Statement

This division is required to provide this information to your most recent employer. Please complete all questions to follow. If you use additional sheets of paper, please mark the pages in order and supply the question number(s) on the page(s). Include all information you feel may be important to making a determination concerning your separation from your employment. **Please print legibly and use ink.**

Name: _____ SSN: _____

1. Most recent employer and their telephone number: _____
2. Supervisor's name: _____
3. Describe the illness or disability that caused your separation from work with this employer.

_____

_____

4. Did a physician advise you that you should stop working for a period of time? Yes _____ No _____
   A. If yes, what was the date you were advised to stop working? _____
5. Did you notify your employer? Yes _____ No _____
   A. If yes, name of person you notified: _____
   B. If no, what were your reasons for not telling the employer: _____

_____

6. What, if any, accommodation did your employer make or offer to make to enable you to continue working? _____

_____

7. If you have lost your job due to a work related injury, did you receive Temporary Total Disability payments from Worker's Compensation? Yes _____ No _____
   A. If yes, has Worker's Compensation released you to return to work? Yes _____ No _____
   B. Worker's Compensation case number: _____ Date _____
   C. Employer's Name: _____
8. If you were released to return to work with your employer, did you contact your employer to return to work? Yes _____ No _____
   A. If yes, date you contacted the employer: _____
      1. Name of person you contacted: _____
      2. Explain what happened: _____

_____

   B. If no, why? _____

_____

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Name: _____ SSN: _____

9. Do you have further information that you wish to provide that will be helpful in determining your benefit eligibility? _____

_____

Claimant's Certification: The above facts are true to the best of my knowledge and belief. I am aware that this information will be verified and a copy of my statement will be given to my former employer. I am aware that I may still be required to secure documentation from my physician(s), and/or the Division of Worker's Compensation for the purposes of determining my potential eligibility for unemployment insurance benefits.

Attach any additional supporting documentation that you wish to be used in the determination of your benefit eligibility.

Claimant's Signature: _____ Date: _____

Return to:

Wyoming Department of Employment, Unemployment Insurance Division, P.O. Box 2760, Casper WY 82602